

# TRICARE Pharmacy Program Medical Necessity Form for Cialis (Tadalafil) and Viagra (Sildenafil)

This form applies to the TRICARE Mail Order Pharmacy (TMOP) and the TRICARE Retail Pharmacy Program (TRRx) and may be found on the TRICARE Pharmacy website at [www.tricare.osd.mil/pharmacy/medical-nonformulary.cfm](http://www.tricare.osd.mil/pharmacy/medical-nonformulary.cfm). It must be completed and signed by the prescriber.

- **Levitra** is on the DoD Uniform Formulary at a **\$9** cost share. **Cialis and Viagra** are non-formulary, but available to most beneficiaries at a **\$22** cost share.
- You do **NOT** need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain Cialis or Viagra at the \$22 non-formulary cost share. The purpose of this form is to provide information that will be used to determine if the use of Cialis or Viagra *instead of Levitra* is medically necessary. If the use of Cialis or Viagra is determined to be medically necessary, non-active duty beneficiaries may obtain Cialis or Viagra at the \$9 formulary cost share.
- Active duty service members may not fill prescriptions for Cialis or Viagra unless it is determined to be medically necessary *instead of Levitra*. There is no cost share for active duty service members at any DoD pharmacy point of service.
- PDE-5 inhibitors require prior authorization for male patients under the age of 50 for erectile dysfunction and all patients for pulmonary arterial hypertension. This form does **NOT** fulfill prior authorization requirements. Please see: [www.tricare.osd.mil/pharmacy/prior\\_auth.cfm](http://www.tricare.osd.mil/pharmacy/prior_auth.cfm) for more information. Quantity limits apply to all patients.

<b>MAIL ORDER</b>	<b>If the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here</b> <input type="checkbox"/>	<b>RETAIL</b>	<b>If the prescription is to be filled at a retail network pharmacy, check here</b> <input type="checkbox"/>	<b>MTF</b>	The medical necessity criteria outlined on this form also apply at Military Treatment Facilities (MTFs). <ul style="list-style-type: none"> <li>• Non-formulary medications are available at MTFs only if both of the following are true:             <ul style="list-style-type: none"> <li>▪ The prescription is written by a military provider or, at the discretion of the MTF, a civilian provider to whom the patient was referred by the MTF.</li> <li>▪ The non-formulary medication is determined to be medically necessary.</li> </ul> </li> <li>• Please contact your local MTF for more information. There are no cost shares at MTFs.</li> </ul>
	<ul style="list-style-type: none"> <li>• The completed form and the prescription may be <b>faxed</b> to <b>1-877-283-8075</b> or 1-602-586-3915 OR</li> <li>• The patient may attach the completed form to the prescription and <b>mail</b> it to: <b>Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b></li> </ul>		<ul style="list-style-type: none"> <li>• The provider may <b>call</b>: <b>1-866-684-4488</b> OR</li> <li>• The completed form may be <b>faxed</b> to <b>1-866-684-4477</b></li> </ul>		

There is no expiration date for approved medical necessity determinations.

## Step 1 Please complete patient and physician information (Please Print)

<b>1</b>	Patient Name: _____ Physician Name: _____ Address: _____ Address: _____ _____ Sponsor ID # _____ Phone #: _____ _____ Secure Fax #: _____
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## Step 2 Please complete the clinical assessment:

<b>2</b>	<b>The patient cannot be treated with Levitra for one of the following reasons:</b>
	1. The patient had a hypersensitivity reaction to Levitra. <span style="float: right;"><input type="checkbox"/></span>
	2. The patient has congenital or acquired QT prolongation. <span style="float: right;"><input type="checkbox"/></span>
	3. The patient is receiving a class IA (e.g., quinidine, procainamide) or class III (e.g., amiodarone, sotalol) antiarrhythmic agent. <span style="float: right;"><input type="checkbox"/></span>
	4. The patient is being treated for pulmonary arterial hypertension with sildenafil. <span style="float: right;"><input type="checkbox"/></span>
	5. The patient has experienced significant adverse effects from Levitra. A description of the adverse effect is REQUIRED: <span style="float: right;"><input type="checkbox"/></span> _____ _____
	6. The patient has tried Levitra for at least 90 days, titrated to the maximum recommended dose, and experienced significant decrease in erectile function compared to previous therapy with Cialis or Viagra. <span style="float: right;"><input type="checkbox"/></span>
	7. The patient has tried Levitra for at least 90 days, titrated to the maximum recommended dose, and experienced no improvement in erectile function. <span style="float: right;"><input type="checkbox"/></span>

## Step 3 I certify the above is correct to the best of my knowledge. Please sign and date:

<b>3</b>	_____ Prescriber Signature	_____ Date
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